South Dakota Board of Technical Education
Academic Affairs
Duplication Review of Lake Area Technical College's Proposed AAS in Radiologic Technology
June 2026

Purpose

This memo responds to the questions the Committee on Academic Affairs and Institutional Effectiveness (CAAIE) raised about Lake Area Technical College's (LATC) application for a new Associate of Applied Science (AAS) in Radiologic Technology. During the CAAIE's Proposed Program Review Call meeting on April 23, 2026, the committee asked Board staff to compile additional information in three areas to inform their decision on program approval: (1) whether the existing programs could be expanded instead of adding a new one, (2) whether there is enough clinical placement capacity, and (3) how the campuses will coordinate going forward. Each is addressed below, followed by a Board staff recommendation.

Area 1: Warranted Duplication (Expand Existing vs. Add New)

A central question for the committee is whether the demand could be met by expanding the existing programs at MTC and WDTC rather than approving a new program at LATC. Board policy (BP 303.2) speaks to part of this question and outlines three conditions that can justify duplication:

1. The proposed program meets an unmet local, regional, and/or state demand.
2. The proposed program is supported through local, regional, and/or state industry partnerships.
3. The proposed program increases access for location-bound students.

LATC addresses all three conditions in Prompt 2.4 of its application (pp. 4-6), documenting the workforce shortage, the industry support behind the program, and the access gap for students in its service area. The policy does not establish numeric thresholds for meeting a condition, so the determination is a matter of judgment. Based on their review of the application against these conditions, Board staff believes that LATC's proposed AAS in Radiologic Technology meets all three and that program duplication would be considered warranted.

Area 2: Capacity

The question for this area is whether every student who needs a clinical placement can get one. To answer it, Board staff worked with the campuses to compare the number of students needing placement each year at full implementation against the reported capacity of the clinical sites. The system-level picture is summarized below, and a more detailed overview is reflected in Appendix A.

- The three programs expect to place 96 students in clinical rotations each year at full implementation and report a combined clinical site capacity of 132, a system-wide surplus of +36.

- By institution: LATC shows a need of 28 against a capacity of 43 (+15), MTC shows 28 against 47 (+19), and WDTC shows 40 against 42 (+2).

- Of the 72 clinical sites across the system, 56 are unique to a single institution and 16 are shared between two. No site is currently shared by all three programs.

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Overall, reported capacity is greater than projected need at both the system and institutional levels, which suggests institutions can place every student who needs a clinical site.

Two points are worth keeping in mind when reading these numbers. First, the capacity figures count the total number of placements available, but they do not show whether every site can provide each type of training a student needs. Some experiences, such as certain specialty rotations, are offered at only a few sites, so capacity for those specific experiences can be tighter than the totals suggest. Second, as MTC notes in its memo, the number of students a site is approved to take is sometimes higher than the number it can comfortably handle at one time. Both points are practical considerations the campuses will need to manage on an ongoing basis. The coordination framework in the next section describes a structure to work through these details over time.

Area 3: Coordination

The remaining concern is how the three campuses will manage shared clinical sites on an ongoing basis, both to keep any one program from crowding out another and to give the committee confidence that issues will be resolved at the appropriate level. To address this concern, Board staff recommends that the campuses adopt a shared coordination framework, such as the version reflected in Appendix B. The framework provides high-level guardrails in three main process areas and outlines a structured escalation path.

The three process areas are:

- Affiliation agreements. When a campus adds a new agreement or adjusts an existing one at a shared site, it provides notice to the other affected campus. The guardrail is built on notice and transparency rather than approval rights, which preserves each campus's autonomy while ensuring no one quietly locks up a shared site.

- Clinical capacity. Campuses follow the site-defined maximum number of students onsite at a given time, honoring the partner's stated comfort level rather than its theoretical approved capacity.

- Scheduling. Campuses coordinate with one another and with shared sites to offset heavy clinical loads, including by using days, evenings, weekends, and shifts that existing programs do not occupy.

To keep coordination at the local level, the framework uses a tiered escalation path:

- Tier 1, Program Directors. Direct, ongoing coordination and the first point of contact for any concern.

- Tier 2, Academic Vice Presidents and CAOs. Engaged in writing when Program Directors cannot resolve an issue within an agreed timeframe.

- Tier 3, Presidents. Engaged when the CAOs cannot resolve the issue.

- Tier 4, Board staff. Engaged only after the campus tiers have been exhausted.

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Recommendation

Based on the three areas above, Board staff recommends that the Board approve LATC's proposed AAS in Radiologic Technology. The three conditions in BP 303.2 are met, the system-level comparison shows enough clinical capacity to meet projected need, and a coordination framework is available to manage shared sites responsibly over time.

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APPENDIX A

Radiologic Technology Clinical Site Capacity and Placement Summary

This summary provides a high-level overview of clinical site availability and anticipated student placement needs across the participating institutions. The analysis is intended to support planning discussions by comparing projected placement demand at full program implementation with reported clinical site capacity.

Key Considerations

This analysis is based on several important assumptions and limitations:

- Student placement need reflects anticipated annual demand at full enrollment/program implementation.
- Reported clinical site capacity represents total placement opportunities and does not account for specific competencies or specialty experiences that may only be available at certain clinical sites.
- While some clinical sites are shared across institutions, no clinical site is currently shared by all three institutions. Existing overlaps occur between two institutions only.

1. Clinical Site Information

This section summarizes the clinical site landscape across campuses. It provides an overview of total clinical sites, distinguishing between sites that are unique to a single institution and those that are shared across institutions, along with associated capacity.

Table 1. System Clinical Site Summary

The following table provides a system-level summary of clinical sites, distinguishing between sites that are unique to a single institution and those shared across institutions.

Measure	Total
Total Clinical Sites	72
Unique Clinical Sites	56
Shared Clinical Sites (Used by Multiple Institutions)	16

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Table 2. Institutional Clinical Site and Capacity Summary

The following table summarizes the number of clinical sites and total reported student placement capacity for each institution. Together, these figures provide a high-level view of the clinical resources available to support student placements.

Institution	Number of Clinical Sites	Total Student Capacity
LATC	28	43
MTC	20	47
WDTC	24	42
System Total	**72**	**132**

2. Need vs. Capacity

This section compares projected annual student placement needs at full program implementation with reported clinical site capacity. The intent is to provide a high-level assessment of whether current clinical partnerships appear sufficient to support anticipated demand.

Table 3. Annual Placement Need (Full Implementation)

The following table summarizes the projected annual number of students requiring clinical placement at full program implementation for each institution.

Institution	Students Requiring Clinical Placement
LATC	28
MTC	28
WDTC	40
System Total	**96**

Program Structure Considerations for Placement Need

Annual clinical placement need varies by institution based on program design and timing of clinical education:

- LATC: Number is based on projected enrollment in years two and three of program start.
- MTC: Second-year students complete a 12-month full-time clinical rotation.
- WDTC: Students begin clinical experiences in the first semester and continue across all five program semesters.

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Table 4. Reported Capacity Compared with Need

The following table compares projected annual placement need with reported clinical site capacity for each institution. This comparison provides a high-level view of potential capacity alignment at both the institutional and system level.

Institution	Placement Need	Reported Capacity	Difference
LATC	28	43	+15
MTC	28	47	+19
WDTC	40	42	+2
System Total	**96**	**132**	**+36**

Key Takeaways

- At full implementation, the participating institutions anticipate placing 96 students annually and report a combined clinical placement capacity of 132 students.
- Reported capacity exceeds projected annual placement need on a system-wide basis.
- Of the 72 clinical sites identified, 56 are unique to a single institution and 16 are shared across institutions. No clinical site is currently shared among all three institutions

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APPENDIX B

Clinical Coordination Framework: Radiologic Technology Programs

Purpose

This framework documents how LATC, MTC, and WDTC coordinate on shared clinical sites for their Radiologic Technology programs. It affirms the campuses' commitment to working together, captures existing practices so all parties share the same understanding, and establishes a clear process for raising and resolving concerns. The intent is to keep coordination at the campus level and to give the institutions a consistent way to manage shared clinical resources over time.

Parties and Scope

This framework applies to LATC, MTC, and WDTC and to the clinical sites used by their Radiologic Technology programs. It covers three ongoing areas: affiliation agreements, clinical capacity, and scheduling. It applies to sites that are shared by more than one campus and to sites that could become shared.

Guiding Principles

These are the shared guardrails the campuses agree to operate under:

- Resolve at the lowest level. Issues are worked out between Program Directors first and only move up when they cannot be settled locally.
- Communicate early. Campuses give each other advance notice of changes that could affect a shared site, rather than after the fact.
- Protect site relationships. No campus takes an action at a shared site that knowingly undermines another program's standing with that site.
- Preserve campus authority. Each campus keeps responsibility for its own agreements, accreditation, and students. This framework adds coordination, not approval rights.
- Keep students central. Decisions protect clinical access and quality for students across all three programs.
- Document what exists. Current practices are written down so all parties share the same understanding.

Roles

- Program Directors (primary coordination). Own the day-to-day coordination across all three process areas. They are the first point of contact for any concern, maintain the shared documentation described below, and meet on a set cadence [for example, at least once each semester and as needed].

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- Academic Vice Presidents / Chief Academic Officers (CAOs). Engaged only when Program Directors cannot resolve an issue locally. They review the referred issue and work toward resolution.

- Presidents. Engaged only when the CAOs cannot resolve an issue.

- Board staff. Engaged only after the campus tiers have been exhausted and the campuses still cannot resolve the issue. Board staff facilitate a resolution or, if necessary, make a determination.

Process Area 1: Affiliation Agreements

Each campus keeps the authority to establish and manage its own affiliation agreements. This framework adds transparency so that a new or changed agreement at a shared site does not surprise another program or create unplanned capacity pressure.

- Before entering a new affiliation agreement at a site currently used by another campus, the initiating Program Director notifies the other Program Director(s) in writing, in advance.

- Before materially modifying an existing agreement at a shared site (for example, changing student counts or rotation timing), the initiating Program Director notifies the other Program Director(s).

- The receiving Program Director(s) review and respond within [X business days], noting any anticipated capacity or scheduling impact.

- Where a concern is raised, the Program Directors work it out directly before the agreement is finalized.

- The initiating Program Director records the new or changed shared-site agreement on the shared site list so all three programs have current visibility.

- For a site not currently shared, no advance notice is required, but the initiating Program Director still records the site on the shared list so others have visibility if it becomes shared later.

Process Area 2: Clinical Capacity

The clinical site sets its own maximum capacity. The campuses coordinate so that their combined use does not exceed what a shared site can support, consistent with each program's JRCERT requirements.

- For each shared site, the Program Director documents the site-defined maximum number of students onsite at one time and how the site determined it, in coordination with the site's clinical coordinator.

- Where two or more campuses use the same site, the Program Directors jointly confirm the site's total capacity and agree in writing on how that capacity is allocated among the programs.

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- The Program Directors revisit each shared-site allocation [annually, or before each scheduling cycle] and whenever a program's enrollment or the site's capacity changes.

- If demand exceeds a shared site's capacity, the Program Directors first attempt to resolve it directly with each other and the site, using the guiding principles above.

Process Area 3: Scheduling

Campuses and sites coordinate rotations so that students from different programs are not double-booked at a shared site and no site is over capacity at a given time.

- By [date each cycle], each Program Director shares its projected clinical rotation schedule for shared sites with the other Program Director(s).

- The Program Directors compare schedules, identify overlaps at shared sites, and resolve them directly with each other and the site's clinical coordinator.

- Where the same slot is needed by more than one program, the Program Directors resolve it in good faith using agreed factors (for example, established usage history at the site, available alternative sites, and balancing access across programs).

- Each Program Director confirms the final rotation schedule with the clinical site and shares it with the other Program Director(s).

Communication and Escalation

Most coordination happens at Tier 1 and stays there. Escalation is the exception. It is used only when a level genuinely cannot resolve an issue, and each level documents what it tried before moving up.

- Tier 1: Program Directors. Direct, ongoing coordination on agreements, capacity, and scheduling. First point of contact for any concern.

- Tier 2: Academic Vice Presidents / CAOs. Engaged when Program Directors cannot resolve an issue within [X business days]. The affected Program Directors jointly refer the issue in writing, with a short summary of the disagreement and what was already tried.

- Tier 3: Presidents. Engaged when the CAOs cannot resolve the issue. Same written referral, updated to reflect the Tier 2 attempt.

- Tier 4: Board staff. Engaged only after Tiers 1 through 3 have been exhausted and the campuses still cannot resolve the issue.

Shared Documentation

The Program Directors jointly maintain a simple shared record, the shared site list, that includes each clinical site, which campuses use it, the site-defined capacity, the current allocation among programs, and the status of each affiliation agreement. This record is the practical tool that supports all three process areas and captures the practices campuses are already following.

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Review and Effective Date

The Program Directors review this framework [annually] and update the shared site list and capacity allocations as needed. Material changes are shared with the CAOs. The framework takes effect once endorsed by the three campuses [by the presidents, or by the CAOs].

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